Waterbury Hospital

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Approved 6/24/19 SHN

June 11, 2019

Susan H. Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of CT, Department of Public Health
410 Capital Avenue
Hartford, CT 06134-0308

Dear Ms. Newton:

I am in receipt of your violation letter dated June 6, 2019 identifying the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut found during the Department of Public Health unannounced visits made to Waterbury Hospital beginning April 5, 2019 and concluding April 24, 2019. Waterbury Hospital makes its best efforts to operate in full compliance with both state and federal laws and regulations. Nothing included in this plan of correction is an admission otherwise. Waterbury Hospital submits this plan of correction to comply with its regulatory obligations and does waive any objects or rights of appeal for any of the allegations contained in the department's letter dated June 9, 2019.

Also, per your letter dated June 6, 2019 I acknowledge an office conference has been scheduled for July 2, 2019 at 1:00PM at the Facility Licensing and Investigations Section of the Department of Public Health.

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The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (4) and/or (b) Administration (2) and/or (e) Nursing Service (1) and/or (j) General (6) and/or Connecticut General Statutes 19a-550.

1. *Based on clinical record reviews, facility documentation, interviews and policy review for 2 of 14 patients (Patient #1 and #2) admitted with suicidal ideation and/or self-harm tendencies, the facility failed to ensure that the patients were cared for in a safe environment to prevent self-harm. The findings include the following:

a. Patient #1 presented to the facility on 3/23/19 via ambulance on a Physician Emergency Certificate (PEC) from the mobile crisis unit. The patient was admitted to the in-patient behavioral health unit on 3/25/19 with a diagnosis of depression and suicidal ideations. Patient #1 was noted to be anemic requiring medical intervention and was discharged to a medical unit on 3/27/19 for treatment.

Review of a discharge summary dated 3/27/19 indicated that Patient #1 had been admitted to the behavioral health unit on 3/23/19 with suicidal ideation and indicated that the patient had made three suicide attempts in the past several weeks. While on the behavioral health unit Patient #1 was on every fifteen minute safety checks. During admission, the patient was noted to have anemia, a medical consult was obtained and the decision was made to discharge the patient to a medical floor for treatment.

Patient #1's physician discharge orders dated 3/27/19 at 8:00 PM directed 1:1 observation. A psychiatric consult dated 3/28/19 at 3:23 PM indicated that the patient reported feeling safe while in the hospital and denied any intent or plan to harm him/her self on the (medical) unit. The note indicated that the patient had been communicating effectively on the unit and MD #1 discontinued the 1:1 observation. MD #1 indicated that once medically cleared, Patient #1 would be readmitted to the behavioral health unit.

A nurse's note dated 3/28/19 at 10:21 PM indicated that at 8:55 PM Patient #1 asked to take a shower but RN #1 told the patient no, due to safety concerns. The note indicated that at 9:00 PM, RN #1 found the patient's bathroom door locked and there was no response. RN #1 unlocked the door and found Patient #1 hanging by a belt in the shower.

Review of Patient 1's clinical record identified that the patient was incubated and treated in the intensive care unit. Life saving measures were unsuccessful and the patient expired on 3/30/19.

Interview with RN #1 on 4/8/19 at 10:00 AM indicated that she was assigned to Patient #1 on 3/28/19. RN #1 indicated that the patient was alert and oriented and denied any suicidal ideation. RN #1 stated she and the charge nurse spoke about the patient and decided to move the patient closer to the nurse's station for better visibility after the 1:1 was removed. RN #1 further indicated that at approximately 8:50 PM-8:55 PM the patient asked to use the shower and she informed him/her that s/he couldn't get his/her IV site wet and provided washcloths and towels. RN #1 stated she went to the room next door and upon exiting the room noted Patient #1's room was dark and the TV was off. RN #1 entered the room and noted that the patient was not in the bed and the bathroom door was locked. RN #1 stated she called a code and while going for the crash cart another RN and PCA entered the room, opened the bathroom door and found Patient #1 hanging from the shower rod. Staff lowered the patient to the floor and CPR was initiated. Review of the code sheet indicated that the code was called at 9:00 PM.

Interview with MD #1 indicated that he had seen Patient #1 on 3/28/19 at approximately 4:00 PM. MD #1 indicated that based on his evaluation the patient was not suicidal and the 1:1 supervision was discontinued. MD #1 stated he was not aware that Patient #1's belonging were sent with the patient when the patient is discharged to a medical floor, and if he would have known that Patient #1 was given possession of his/her belongings (belts/shoe laces) on the medical floor, it would have impacted his decision regarding the patient's level of supervision. MD #1 indicated that prior to the event the hospital did not have a policy related to patient belongings. Following the event a policy was instituted on 4/1/19 to ensure that when a patient is transferred off of the BH unit, their belongings are not returned to them until the behavioral health treatment team reviews the patient's situation.

The hospital failed to effectively communicate to the physician that the patient's belongings were returned upon transfer from the psychiatric unit to the medical unit and/or had a policy that directed this practice.

b. Patient #2 presented to the Emergency Department (ED) on 3/27/19 at 9:30 PM with suicidal ideation. Review of the triage assessment indicated that the patient verbalized self-harm. The suicide assessment (P4) indicated that the patient was a high risk for suicide resulting in the need for 1:1 observation per the triage protocol. A physician's order dated

3/27/19 at 9:41 PM directed continuous observation. When Patient #2 was transferred to the ED behavioral health area on 3/28/19 at 1:00 AM the patient was monitored every 15 minutes. The hospital failed to institute continuous observation of the patient in accordance with the physician's order.

Review of the clinical record identified that the patient was seen by the Crisis Worker on 3/28/19 at 9:11 AM who indicated that the patient was a "high" risk for suicide. The Behavioral Health progress note dated 3/28/19 at 12:27 PM indicated that at approximately 12:15 PM, Patient #2 went to the common bathroom located off the main hallway and was in the bathroom for five plus minutes. The note indicated that the RN was at lunch and that the door to the crisis room was left open to be present for patients. Security Guard (SG) #3 was at the desk. Security Guard (SG) #2 heard gasping sounds coming from the bathroom, went to the bathroom door, knocked and then opened the door. SG #2 found Patient #2 on the floor with his/her socks tied together around his/her neck and tied around the toilet paper dispenser.

A nurse's note dated 3/28/19 at 12:27 PM indicated that Patient #2 was found by SG #2 in the behavioral health bathroom gasping for air with a sock tied around his/her neck and tied around the toilet paper holder. Patient #2 was alert and oriented, tearful, no redness to neck noted, lungs were clear to auscultation, and the patient was complaining of a headache and neck soreness. The patient was transferred to the main ED, for a complete medical assessment and a 1:1 sitter was at the patient's bedside. A CT scan of the neck was completed, which was negative.

Interview with Security Guard #2 on 4/24/19 at 9:30 AM indicated that he was a shift supervisor and in his role he rounds on the security guards throughout the day. SG #2 indicated that on 3/28/19 he went to the behavioral health ED and was rounding, checking with the security guard on duty and looking at the video cameras (of the patients in the behavioral health ED). SG #2 asked SG #3 (who was stationed in the behavioral health ED and the nurse was on lunch break) where Patient #2 was, and was informed that the patient was in the bathroom. SG #2 went to the bathroom and knocked. When there was no answer he listened at the door, heard gagging and announced he would be opening the door. SG #2 indicated that when he opened the door Patient #2 was on the floor with his/her head against the wall and he identified that the patient had tied the hospital issued socks together and tied them around the toilet paper dispenser and around his/her neck. SG #2 indicated that the patient was gagging and when he removed the socks the patient took a deep breath and was speaking with no issues. SG #2 yelled for help and assisted transferring the patient. Interview with SG #1 on 4/8/19 at 11:00 AM, and SG #2 on 4/24/19 at 9:30 AM indicated

that while in the behavioral health ED their responsibility is to monitor the patients and the environment every 15 minutes. SG's #1 and #2 indicated that they had no training on the facility policies related to patient observation.

Interview with the Director of Security on 4/24/19 at 12:30 PM stated that SG #3 was trained to complete fifteen minute safety and environmental checks, and not continuous observation as ordered.

Interview with the Behavioral Health Manager on 4/8/19 at 10:00 AM indicated that when a patient requests to use the bathroom in the behavioral health ED the patient should be in sight at all times and this was not done.

Interview with the Director of Quality on 4/24/19 at 2:00 PM indicated that it was identified after the incident that the term "Continuous" observation was not in the hospital observation policy. The practice was that continuous observation meant direct line of site, and security guards conducted fifteen minute checks and this was how the behavioral health ED functioned. Additionally the Director identified that staff in the ED were confusing "continuous" observation and "constant" when ordering observation status and that the ED and behavioral health ED staff were re-educated on 4/2/19.

Review of the patient observation policy in place at the time of the incident identified that an observation status is assigned to the behavioral health patient on admission to the behavioral health ED and to the inpatient unit. The policy identified two levels of observation, fifteen minute checks and/or constant staff companion. The category of "continuous" which was ordered for Patient #2 was not identified in the policy.

The hospital failed to ensure that the patient was in line of sight at all times in accordance with the physician's order and as a result, the patient attempted suicide. Immediate Jeopardy was identified on 4/24/19. Based on the following action plan, Immediate Jeopardy was verified as being corrected as of 4/2/19.

Following the incidences involving Patients #1 and #2, the hospital instituted corrective measures that included the development of a psychiatric patient belonging policy, revision of the patient observation policy on 4/2/19 to include continuous observation. The policy indicated that continuous observation required the patient to be in full visual contact by a trained staff member, including when the patient was using the bathroom. The main ED and behavioral health ED staff were re-educated on the revised policy on 4/2/19. Staffing in the behavioral health ED was changed on 3/29/19 from 2 staff to 3 to include a RN, a security

guard and Patient Care Technician who would be available to assist patients with personal needs.

Based on clinical record review, interview and policy review for 1 of 1 patients requiring observation for suicidal ideation (Patient #2) the facility failed to ensure that qualified staff conducted the monitoring. The finding includes the following:

Patient #2 presented to the Emergency Department (ED) on 3/27/19 at 9:30 PM with suicidal ideation. Review of the triage assessment indicated that the patient verbalized self-harm. The suicide assessment (P4) indicated that the patient was a high risk for suicide resulting in the need for 1:1 observation per the triage protocol. A physician's order dated 3/27/19 at 9:41 PM directed continuous observation. When Patient #2 was transferred to the ED behavioral health area on 3/28/19 at 1:00 AM the patient was monitored every 15 minutes, per unit process, and not in accordance with the physician's order.

Review of the clinical record indicated that Patient #2 was seen by the Crisis Worker on 3/28/19 at 9:11 AM who indicated that the patient was a "high" risk for suicide. A behavioral health progress note dated 3/28/19 at 12:27 PM indicated that at approximately 12:15 PM Patient #2 was found in the bathroom with his/her socks tied together around his/her neck and tied around the toilet paper dispenser.

The 3/28/19 progress note at 12:27 PM indicated that the patient was alert and oriented and brought to room 16 (main ED) after being found by security in the behavioral health bathroom with a sock tied around his/her neck and tied around toilet paper holder in the bathroom. Review of the physician's order dated 3/28/19 at 12:29 PM directed 1:1 observation. The nurse's note dated 3/28/19 at 1:24 PM indicated that the patient removed the hub from his/her IV and was bleeding from the IV site.

Interview with Security Guard #1 on 4/8/19 at 11:00 AM indicated that he was instructed to sit with Patient #2 on 3/28/19 after the patient tried to hurt self in the behavioral health ED. SG #1 indicated that he was sitting next to the patient and the patient was fiddling under the blankets but he did not feel comfortable removing the blanket. SG #1 informed the nurse

when he saw her, however, was unable to identify the timeframe for the notification. Upon removal of the blanket by the RN, it was identified that the patient had removed the cap from the IV and was bleeding. SG #1 stated that he had never been trained on how to be a 1:1 companion but was told he had to go for education "this week". Review of SG #1's personnel file with the Healthstream Coordinator on 4/8/19 at 2:00 PM indicated that there

is no formal education provided for performing patient observation, sitting or constant, and that this would be "on the job training".

Interview with Security Gard #2 on 4/24/19 at 9:30 AM indicated that he is the shift supervisor and explained that the security guards role in the behavioral health ED is to complete fifteen minute checks on patients and safety & environmental checks. The facility failed to ensure security staff were trained to conduct 1:1 observations as directed.

Interview with the Director of Security on 4/24/19 at 12:30 PM stated that SG #1 was assigned to watch the patient but did not have specific training in what to watch for, including but not limited to having the patients hands visible at all times, and would not expect the guard to lift the blanket.

Subsequent to this incident all security staff, RN's and PCA's were re-educated on the new patient observation policy which was completed on 4/2/19.

Measures to prevent recurrence:

1a. On April 1, 2019, under the direction of the Chief Nursing Officer; Vice President and Chair, Behavioral Health; and the Director of Nursing, Inpatient Behavioral Health a policy was developed, Center for Behavioral Health: Management of Personal Belongings. Any patient on Pomeroy 8 or BHED that is transferred to a Medical/Surgical unit will not have personal belongings sent with them.

On March 29, 2019 under the direction of the Vice President and Chair, Behavioral Health and Senior Vice President and Chief Medical Officer to assure safety of Behavioral Health patients admitted to an inpatient Medical/Surgical unit all patients determined to be gravely disabled and/or a danger to themselves or others will require 1:1 level of observation if they are transferred to any Medical/Surgical unit.

Pomeroy 8 staff were provided education via email on 4/1/2019 with requirement for signed acknowledgement. The department of education-initiated education with signed acknowledgement to all RN and PCA staff regarding the policy for management of patient personal belongings.

Requirement of observation level of 1:1 for all transfers from P8 or BHED to a Medical/Surgical floor was verbally communicated by the Vice President and Chair, Behavioral Health on 3/29/2019 to the consulting behavioral health providers.

On 4/5/2019, the Senior Vice President and Chief Medical Officer sent a memo regarding the criteria for 1:1 observation via email with acknowledgement receipt to Nursing Supervisors, Hospitalists, PAs, APRNs, and Section Chiefs.

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Ensuring ongoing compliance: Beginning 4/6/2019 Nursing Directors of Medical/Surgical units receiving Behavioral Health patients in transfer from P8 or BHED will perform an audit to acknowledge 1:1 observation is ordered, and the patient's belongings do not accompany them to the Medical/Surgical Unit. One to one feedback will be provided if a deficiency is identified. Documentation of compliance will be tracked and reported monthly for 3 consecutive months to the Performance Improvement Safety Committee for monitoring and Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.

Effective date of corrective action plan: 4/5/2019

Responsibility: Chief Nursing Officer; Director of Nursing, Inpatient Behavioral Health; Vice President and Chair, Behavioral Health and Senior Vice President and Chief Medical Officer.

Measures to prevent recurrence:

1b. On 3/29/19, staffing for the Behavioral Health ED (BHED) was increased to provide 1:1 coverage at all times, across all shifts.

On 4/2/19 the Chief Nursing Officer and the Director of Nursing, Behavioral Health collaborated to develop new staffing guidelines for the Behavioral Health ED to provide additional staffing ensuring 1:1 coverage always in the BHED. Staffing will consist of a minimum of one RN, one PCA and a security officer.

Procedure for implementing plan:

1. On 4/2/2019 the Director of Nursing, Emergency Department collaborated with the Emergency Department educator to provide education regarding, "Triage Guidelines for Patients Requiring Observation" including appropriate orders for observation level. Education was done via classroom instruction, email and staff meetings with attestation completed 4/16/19.
2. On 4/2/2019 Director of Security; Director of Nursing, Behavioral Health; Director of Education and Director of Nursing, Emergency Department collaborated to develop and disperse education to RNs, Security Officers and PCAs regarding observation levels, responsibilities and documentation requirements. Education included definition of observation levels and requirement for 1:1 which always includes staff member to be within an arm's reach of the patient, maintaining visual observation at all times including when the patient is in the bathroom.
3. Additionally, the Chief Nursing Officer and Directors of Nursing collaborated to revise the policy titled, "Initiation and Management of Patient Requiring Observation Outside Behavioral Health". Revisions included a title change to, "Risk Assessment and Management of Patients

Requiring Observation Outside of Behavioral Health", to accurately reflect the purpose of the policy; includes specific interventions and level of observation required for patients at risk of self-harm and an addition of the "Safety Checklist". The Safety Checklist directs staff to remove non-essential items that may pose a risk of self-harm from the area of a patient at risk for self-harm. Under the direction of the Chief Nursing Officer, the organization transitioned to the use of the Columbia-Suicide Severity Rating Scale as the screening tool for suicide risk which was implemented on 4/30/2019.

4. 4/15/2019 classroom education on the use of the Columbia-Suicide Severity Rating Scale was initiated for all RNs and Providers.

Ensuring ongoing compliance:

1.To ensure on-going compliance with staffing guidelines, beginning 4/3/2019 the Director of Nursing, Behavioral Health will audit staffing levels for the BH ED. Non-compliance will be escalated to the Chief Nursing Officer. Documentation of compliance will be tracked and reported monthly until 100% compliance is achieved for three consecutive months to the Performance Improvement Safety Committee for monitoring and Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.

2. Ensuring on-going compliance for appropriate level of observation assignment, an assigned staff member will perform a weekly audit of patient's screened as high risk for suicide for appropriate observation order began 4/15/2019. One to one feedback will be provided if a deficiency is identified. Documentation of compliance will be tracked and reported monthly until 100% compliance is achieved for three consecutive months to the Performance Improvement Safety Committee for monitoring and Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.

Effective date of corrective action plan: 4/30/2019

Responsibility: Director of Nursing, Emergency Department

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (d) Medical Records (3) and/or (e) Nursing Service (1).

2. Based on clinical record reviews, interviews and review of facility policy for three of three sampled patients (Patients # 10, 11, 12) who were reviewed for the use of physical restraints, the facility failed to ensure restraint documentation was complete. The findings include:

    a. Patient #10 was evaluated in the Emergency Department (ED) with a diagnosis of suicidal ideations (SI) and poly substance abuse. A physician's order dated 3/12/19 at 10:05 PM directed the application of soft, locked, four point restraints for

physical abuse towards others. Restraint monitoring documentation from 3/12/19 at 10:05 PM to 11:05 PM identified every fifteen minute safety checks had been completed. However, the medical record lacked documentation identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation, and/or the least restrictive methods attempted.

b. Patient #11 was evaluated in the ED on 3/11/19 at 7:54 PM for inappropriate behaviors such as agitation, head banging, screaming, combativeness and spitting at staff. A physician's order dated 3/11/19 at 8:06 PM directed the application of soft, locked, four point restraints for physical abuse toward others and checks every fifteen minutes while restrained. Restraint monitoring documentation from 3/11/19 at 8:06 PM to 11:01 PM identified every fifteen minute safety cheeks had been completed. However, the medical record lacked documentation identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation and/or the least restrictive methods attempted.

c. Patient #12 was evaluated in the ED on 3/23/19 at 4:21 AM for aggressive, uncooperative, and violent behavior. A physician's order dated 3/23/19 at 9:40 AM directed the application of soft, locked, four point restraints for physical abuse toward others and P# 12 was to be on constant observation. Restraint monitoring documentation from 3/23/19 from 10:57 to 11:55 identified every fifteen minute safety checks had been completed. However, the medical record lacked documentation identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation and/or the least restrictive methodsattempted.

Review of the clinical records with the Behavioral Health Nurse (RN#2) on 4/8/19 at 1:00 PM identified that assessments were completed by nursing every two hours.

During a review of the clinical records and the facility policy on 3/8/19 at 1:00 PM with the Director of Performance Improvement s/he was unable to provide documentation that assessments of the patient's behaviors to justify the continued need for restraints had been completed every fifteen minutes. Additionally, s/he indicated that prior to the electronic medical record program the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation and/or the least restrictive methods attempted were documented on a separate flow sheet.

Review of the facility's restraint monitoring policy directed staff to document safety checks of the patient at least every fifteen minutes while restrained. Safety checks included assessing the patient for signs of injury, nutrition/hydration, circulation, range of motion, hygiene, elimination, affect, the

patients readiness for discontinuation of the restraint or the behavior necessitating the restraint's continued use.

Measures to prevent recurrence:
At the time of the finding it was identified the fields in the electronic record that captured the necessity for continued use of the restraint, the patient's readiness for discontinuation and /or least restrictive methods attempted had been accidentally omitted during the recent electronic medical record up-lift.
On 04/09/2019 a Performance Improvement Coordinator notified information technology of the finding and requested an audit of all the violent restraint fields to validate the availability for staff documentation and/or correct any omitted fields to ensure the required violent restraint fields are available to the staff for documentation. On 4/9/2019 the necessity for continued use and the least restrictive methods attempted field omissions were corrected by IT and available in the electronic record. IT continues to work on the patient's readiness for discontinuation.
IT has modified the electronic record to ensure documentation of identifying the behaviors necessitating the continued use of the restraint, the patient's readiness for discontinuation, and/or the least restrictive methods attempted.
Beginning 5/21/2019 education will be provided to RN staff on the changes in the electronic health record documentation for Violent restraints.
Ensuring ongoing compliance:
To ensure on-going compliance 100% of violent restraint usage will be audited. One to one feedback will be provided if a deficiency is identified. Documentation of compliance will be tracked and reported monthly until 100% compliance is achieved for three consecutive months to the Performance Improvement Safety Committee for monitoring and Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.
Effective date of corrective action plan: 5/31/2019
Responsibility: Senior Director, Information Technology Operations, Chief Nursing Officer

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (a) Physical Plant (4) and/or (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6).

3. *Based on clinical record reviews, review of facility documentation, review of policies/procedures, interviews, and tour of the facility for 1 of 10 patients reviewed for suicidal ideations and safety needs (Patient #2) the facility failed to ensure that the patient was cared for in a psychiatrically safe environment which resulted in a finding of Immediate Jeopardy.

Immediate Jeopardy was verified as corrected as of 4/2/19. The finding includes:

a. Patient #2 presented to the Emergency Department (ED) on 3/27/19 at 9:30 PM with suicidal ideation. Review of the triage assessment indicated that the patient verbalized

self-harm. The suicide assessment (P4) indicated that the patient was a high risk for suicide resulting in the need for 1:1 observation per the triage protocol. A physician's order dated 3/27/19 at 9:41 PM directed continuous observation. When Patient #2 was transferred to the ED behavioral health area on 3/28/19 at 1:00 AM the patient was monitored every 15 minutes. The hospital failed to institute continuous observation of the patient in accordance with the physician's order.

Review of the clinical record identified that the patient was seen by the Crisis Worker on 3/28/19 at 9:11 AM who indicated that the patient was a "high" risk for suicide. The Behavioral Health progress note dated 3/28/19 at 12:27 PM indicated that at approximately 12:15 PM, Patient #2 went to the common bathroom located off the main hallway and was in the bathroom for five plus minutes. The note indicated that the RN was at lunch and that the door to the crisis room was left open to be present for patients. Security Guard (SG) #3 was at the desk. Security Guard (SG) #2 heard gasping sounds coming from the bathroom, went to the bathroom door, knocked and then opened the door. SG #2 found Patient #2 on the floor with his/her socks tied together around his/her neck and tied around the toilet paper dispenser.

A nurse's note dated 3/28/19 at 12:27 PM indicated that Patient #2 was found by SG #2 in the behavioral health bathroom gasping for air with a sock tied around his/her neck and tied around the toilet paper holder. Patient #2 was alert and oriented, tearful, no redness to neck noted, lungs were clear to auscultation, and the patient was complaining of a headache and neck soreness. The patient was transferred to the main ED, for a complete medical assessment and a 1:1 sitter was at the patient's bedside. A CT scan of the neck was completed, which was negative.

Interview with Security Guard #2 on 4/24/19 at 9:30 AM indicated that he was a shift supervisor and in his role he rounds on the security guards throughout the day. SG #2 indicated that on 3/28/19 he went to the behavioral health ED and was rounding, checking with the security guard on duty and looking at the video cameras (of the patients in the behavioral health ED). SG #2 asked SG #3 (who was stationed in the behavioral health ED and the nurse was on lunch break) where Patient #2 was, and was informed that the patient was in the bathroom. SG #2 went to the bathroom and knocked. When there was no answer he listened at the door, heard gagging and announced he would be opening the door. SG #2 indicated that when he opened the door Patient #2 was on the floor with his/her head against the wall and he identified that the patient had tied the hospital issued socks together and tied them around the toilet paper dispenser and around his/her neck. SG #2 indicated that the patient was gagging and when he removed the socks the patient took a deep breath and was speaking with no issues. SG #2 yelled for help and assisted transferring the patient.

Interview with the Director of Security on 4/24/19 at 12:30 PM stated that SG #3 was trained to complete fifteen minute safety and environmental checks, and not continuous observation as ordered.

Review of the Risk Assessment dated January 2019 identified that the toilet paper holders were recessed and designed for use without a paper roll.

Interview with Nurse Manager on 4/5/19 at 9:30 AM identified that the toilet paper holder in the bathroom of the behavioral health ED had not been identified as a ligature risk prior to 3/28/19.

The hospital failed to ensure that the environment was safe preventing patient injury. Immediate Jeopardy was identified on 4/24/19 and verified as corrected as of 4/24/19 based on the implementation of their action plan.

Following the incident on 4/2/19, the hospital instituted corrective measures that included removal the toilet paper holder in the BH ED and on the Behavioral Health inpatient unit. Door handles (31) were changed in the BH ED and on the inpatient BH unit, phone cords on the BH unit were shortened, sink faucets on the inpatient BH unit were changed and door latches were removed. A check list was developed to be completed for patients identified as high risk for suicide outside of the BH Units to ensure that potential ligature risks were removed.

Measures to prevent recurrence:
On 4/1/2019 Toilet paper spools were removed from the BH ED bathroom and in-patient behavioral health patient bathrooms.
On 4/3/2019 phone cords in the BH unit were shortened to less than 14 inches.
On 4/4/2019 a "Safety Checklist" was developed and implemented for removal of non-essential items that my pose a risk of self-harm for patients screened at high risk for suicide in patient care areas of the emergency department and non-behavioral health areas.
On 4/5/2019 31 door handles in the BH ED and BH unit were replaced with ligature resistant door handles.
On 4/5/2019 the door latches were removed from the patient bathroom doors on BH unit.
On 4/11/2019 Ligature resistant faucets were installed in the BH dining area.
On 3/29/19, staffing for the Behavioral Health ED (BHED) was increased to provide 1:1 coverage always, across all shifts.

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On 4/3/2019 the Directors of Performance Improvement, Risk Management and Facilities collaborated to revise the schedule of environmental risk assessments ensure that the patients are cared for in a psychiatrically safe environment.

The Environment of Care team will perform an Environmental risk assessment utilizing a validated tool twice yearly in both the Behavioral Health and Non-Behavioral Health patient areas.

On 4/2/19 the Chief Nursing Officer and the Director of Nursing, Behavioral Health collaborated to develop new staffing guidelines for the Behavioral Health ED to provide additional staffing ensuring 1:1 coverage always in the BHED. Staffing will consist of a minimum of one RN, one PCA and a security officer.

To allow for better assessment of our patients, under the direction of the Chief Nursing Officer, the organization transitioned to the use of an evidence-based tool, the Columbia-Suicide Severity Rating Scale, as the screening tool for suicide risk which was implemented on 4/30/2019.

The Environment of Care team are tasked with conducting On-going Environmental risk assessment utilizing a validated tool twice yearly in both the Behavioral Health and Non-Behavioral Health patient areas.

Beginning 4/5/2019 all BH ED staff were educated on the 4/23/2019Guidelines for BH ED Staffing.

On 4/2/2019 the Director of Nursing, Emergency Department collaborated with the Emergency Department educator to provide education regarding, "Triage Guidelines 4/16/2019 for Patients Requiring Observation" including appropriate orders for observation level. Education was done via

classroom instruction, email and staff meetings with attestation completed 4/16/19.

On 4/2/2019 Director of Security; Director of Nursing, Behavioral Health; Director of Education and Director of Nursing, Emergency Department collaborated to develop and disperse education to RNs, Security Officers and PCAs regarding observation levels, responsibilities and documentation requirements. Education included definition of observation levels and requirement for 1:1 which always includes staff member to be within an arm's reach of the patient, maintaining visual observation always including when the patient is in the bathroom.

Ensuring ongoing compliance:

The EOC team will perform at a minimum twice-yearly environmental risk assessment to identify potential risks for self-harm or ligature risk. For risks identified a corrective action plan is required to be submitted to the Environmental Safety Officer. The Environmental Risk Assessment data will be reported by the EOC team to the Performance Improvement Safety Committee for monitoring and

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Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.
To ensure on-going compliance with staffing guidelines, beginning 4/3/2019 the Director of Nursing, Behavioral Health On-going will audit staffing levels for the BH ED. Non-compliance will be escalated to the Chief Nursing Officer. Documentation of compliance will be tracked and reported monthly until 100%
compliance is achieved for three consecutive months to the Performance Improvement Safety Committee for and Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.
Ensuring on-going compliance for appropriate level of observation assignment, an assigned staff member will
perform a weekly audit of patient's screened as high risk for suicide for appropriate observation order began 4/15/2019. One to one feedback will be provided if a deficiency is identified. Documentation of compliance will be tracked and reported monthly until 100% compliance is achieved for three consecutive months to the Performance Improvement Safety Committee for monitoring and Oversight. The Performance
Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.
Designated staff members began auditing compliance with the "Safety Checklist" on 4/5/19. For instances of
noncompliance observed, one to one feedback will be provided. Documentation of compliance will be tracked and reported monthly for 3 consecutive months to the Performance Improvement Safety Committee for monitoring and Oversight. The Performance Improvement Safety Committee reports to the Staff Executive Committee and the Local Advisory Board.
Effective date of corrective action plan: 4/30/2019
Responsibility: Director of Facilities, Chief Nursing Officer, Environmental Safety Officer, Director of Security and Director, Nursing Emergency Department.

Respectfully submitted,
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